CLINICAL ESSAYS ON INSANITY.

By JOHN T. MACLACHLAN, M.D.,
DUMBARTON,
LATE SENIOR ASSISTANT, HARTWOOD ASYLUM, LANARKSHIRE.

CLINICAL ESSAYS ON INSANITY.

CLINICAL ESSAYS ON INSANITY.

BY

JOHN T. MACLACHLAN, M.D.,
Late of DUMBARTON, Glasgow
LATE SENIOR ASSISTANT, HARTWOOD ASYLUM, LANARKSHIRE.

REPRINTED FROM THE "GLASGOW MEDICAL JOURNAL."

GLASGOW:
PRINTED BY ALEX. MACDOUGALL, 68 MITCHELL STREET.
1897.

CONTENTS.

I.

MELANCHOLIC, MANIACAL, AND DEMENTED STATES.

CLINICAL ESSAYS ON INSANITY.

—o—

I.

MELANCHOLIC, MANIACAL, AND DEMENTED STATES.

INSANITY reveals itself in a patient when his natural instincts, feelings, and impulses are perverted or lost, when his observation and judgment become so defective that he labours under false beliefs, out of which he cannot be reasoned, and when his sense organs fail to register impressions correctly, so that hallucinations arise and cloud his mind. Insanity, therefore, implies a perversion or loss of the natural faculties and feelings of man. It does not necessarily mean that the whole man is changed. It may consist in flaws or slight defects of mind. It may be even compatible with a man leading a useful life, provided he does not obtrude his own special weakness on his neighbours. It almost always implies a loss of the higher forms of mental energy. As in the evolution of man the finer faculties are the last to be developed, so when mental deterioration sets in these commonly are the first to be lost or impaired.

The diagnosis of insanity rests to a large extent on the questions—How is this patient different from his former self when he was in sound health? In what way does his conduct, his language and beliefs differ from his neighbours who are reckoned to be sound in mind? How is he affected by his surroundings?

A patient may talk intelligently enough, but his actions may show that he does not act in accordance with his beliefs. He may have lost will power, so that he is unable to avoid doing harm to himself. Thus, some patients converse quite rationally, and yet, if opportunity presented itself, would

commit suicide, and frequently they cannot give any adequate explanation of their destructive tendencies. It would seem that they are the victims of their impulses, and have little or no inhibitory power over them.

Suicidal patients are generally depressed, listless, and speechless, and have ceased to find the outer world of sufficient interest to arouse their attention, and they do not respond in the usual way to external influences. They tend to become untruthful, cease to love their neighbours, and live in a world all to themselves. They heed little about food, have feeble digestion, constipated bowels, and often a catarrhal condition of the stomach. They are generally pale, with dull eyes, drooping eyelids, and inactive muscles.

Patients the victims of melancholia are apt to be suicidal in their tendencies, according to the degree of anguish occupying their mind. The hypochondriacal form of melancholia is an exception. Here the patient's depression arises from an intense desire to live and to feel well, but they have subjective sensations which become real evils as the mind of the patient ponders over them. These sensations by and by become fixed and dominant thoughts in the mind, and tinge the complexion of his whole life, and constitute his insanity. Again, melancholia may not amount to anything more than a simple loss of energy, both bodily and mental. Melancholics avoid all pursuits likely to draw upon their feeble capital. They are listless, quiet and pensive in manner, generally preferring to sit in a corner of the room out of the way and not trouble or be troubled by any one.

Again, melancholics have generally a feeble circulation, a depressed state of the body reflecting a depressed state of the mind. They lack spontaneity of thought and action. As a rule they tend to become thin, but this emaciated condition is probably dependent on gastric troubles. Some melancholics are quite stout, although always flabby. Their hands are apt to be the seat of chilblains in cold weather. Their head is generally drooping, and they walk in a sort of automatic way. Their time reaction is slow. Melancholia may occur under a great variety of forms, from a simple loss of energy to a state of the most abject misery, in which destructive tendencies may assert themselves in a terrible manner—the patients seizing any knives they see to cut their throat, &c.

There is a strange form of melancholia known as resistive melancholia. This resistive form is distinguished by the apathy of the patient and by the resistance the patient offers to any change of position or attitude. The attendant feels

them to be so contrary in their ways. Such patients generally sit still in a corner, but offer stout resistance, usually of a passive character, to being moved. In its acute form the disease is a highly dangerous one, the sufferers refusing food and drink or even to be comforted in any way, and not infrequently they die of exhaustion.

Again, it is not uncommon to have melancholia mixed up with a good deal of excitement. This is apt to take place in acute melancholia, where the tension generated by the extreme misery finds vent in wringing of the hands and strong suicidal or even homicidal exhibitions.

The gentler forms of the disorder are witnessed in patients who are listless, and wish to sit in their chairs all day in dreamy or vacuous states of mind, having no heart for work or play, finding it almost impossible to rouse themselves for any duty or even conversation of any kind. Many of these cases depend on high tension pulse, with defective elimination of waste products and occasionally with albuminuria. Disease of the heart and atheromatous arteries are not uncommon in this condition. Defective and languid circulation through the brain is a predisposing if not an actual exciting cause in many cases. Aperients, liver, skin, and kidney stimulants are most serviceable in such states, with iron and strychnine tonics.

Subacute catarrh of the stomach and bowels is so often associated with depressed and gloomy states of the mind as to be regarded in the light of cause and effect. It is accompanied with a lack of ambition and a feeling that life is not worth living and a burden. In the young and impulsive, suicidal thoughts are apt to arise and be nurtured and carried into execution. Here, foods that readily ferment in the stomach should be avoided, and alkalies given to clear away the mucus along with easily digested nitrogenous food. Stimulants also will be needed, and perhaps antiseptics to check gastric fermentative changes.

Cases occur from time to time in which melancholics sink into a state of stupor and are practically dead to the world. There may or there may not have been a previous state of excitement of a maniacal character. These cases occur more frequently in females than in males. Occasionally some moral shock can be traced as the exciting or predisposing cause of the attack. In well marked cases, the patient is motionless, mindless, and speechless, sitting on the chair with hanging down head, somewhat puffy looking face, but not actually œdematous; the facial lines are blurred, and all the tissues

lacking tone and hanging loose. The eyelids are generally closed and adhering from slimy mucus. The mouth generally is slavering, and the patient can scarcely be roused from this lethargic state, being almost insensitive to pain. The patients may be pinched severely, but they do not seem to mind it, and will scarcely move out of the way of the aggressor. They have to be helped with their food. The pupils and knee-jerks may be normal, and on recovery the patients may remember most, if not all, that transpired during their illness. There is generally a catarrhal condition of the digestive organs, and even a purulent discharge from the nostrils. This stuporose state may last for weeks or months and the patients recover, but even then they frequently remain listless, indifferent, and useless.

The maniacal forms of insanity are shown in the patients' behaviour, chiefly in their want of harmony to their environment. Slight causes disturb their mental equilibrium. A look, a gesture may excite a violent outbreak of temper. Maniacal patients are unduly irritable, impulsive, and aggressive. The mental reflexes are very acute and exaggerated. Their inhibitory power over the lower centres is greatly defective. As a consequence, noisy speech, disorderly conduct, and incessant restlessness are prominent tokens of this condition. Maniacal patients are apt to be very incoherent, flying off at a tangent from the subject matter of conversation, and to some extent the degree of power of concentration may be taken as a fair guide in prognosis.

In the more acute forms of maniacal excitement, all the functions and faculties of man may be seriously disturbed. The skin is apt to get dry, wrinkled, parched, and earthy coloured; the digestive tract is prone to suffer in a similar way, the tongue becoming dry and baked-looking, sordes collecting around the lips and teeth, foamy saliva gathering between the tongue and teeth, and a peculiar slaty tinge appearing on the face; while the sclerotic coats of the eyeball appear unduly visible, and a strange light in the pupil of the eye. Frequently there is a wild tragic expression of countenance, the eyeballs being very prominent, the feature muscles continually moving; the hair being dry, and masses of it becoming grey and tossed about in wild confusion.

This restless state may find expression chiefly in noisy, incoherent bawling and shouting or in muscular unrest. This motor excitement resembles choreic movements a good deal, consisting in little tremulous jerky movements, chiefly of the arms, while the patients clutch at objects very firmly—a

sort of tonic spasm. The knee-jerks are generally somewhat exaggerated, but the pupils are not necessarily dilated. As a rule the pupils do not respond well to the stimulus of light. The patients generally look as if they were in a state of alarm or terror, the gestures being as if they were repelling some one. Then delusions of identity and hallucinations of hearing are very outstanding features of acute maniacal excitement. The nature of the delusions is largely influenced by the general character of the patient and his antecedent life. Thus the minds of some raving maniacs are filled with religious doubts and fears and misgivings; they may imagine themselves martyrs for the sake of their religion, and invite one to kill them for their beliefs. They have lost all notion of the proper relation of things, and some peculiar thought or feeling or desire may dominate their conduct entirely. More frequently their mind is a mass of wild and tangled ideas succeeding each other in disconnected fashion and cropping up in wild and rampant profusion.

As a rule, the appetite for food is entirely gone, and the sufferer is frequently under the dread of being poisoned, and may refuse food entirely on this score, requiring to be fed by the stomach-tube to prevent death by exhaustion or starvation.

Acute typhomania, to which most of the above description applies, is a very fatal malady, on account of the great motor excitement and the accompanying exhaustion, as also on account of the great difficulty in feeding such patients and the disordered state of the digestive organs. Further, the prospects of recovery may be seriously handicapped through the loss of sleep, and sedative drugs may be urgently needed; but these latter require to be pushed, otherwise they are practically useless. Hyoscine ($\frac{1}{200}$ to $\frac{1}{100}$ gr.) hypodermically is most useful where muscular unrest is the chief feature of the disease. Sulphonal, 20 to 30 gr., and large doses of bromide of potassium are also useful and safe. The bowels should be cleared out once and for all with croton oil (1 to 2 minims), and it is astonishing to observe how a sharp purgative relieves many of the symptoms. The diet is important, and should be liquid foods, with artificial helps such as pepsine. Large quantities of stimulants are necessary, and the feeding-tube will be in constant demand.

In the subacute forms of mania, the patients may be quiet, well-behaved, and industrious so long as they are humoured and wheedled, but they are, nevertheless, very "touchy," and are abnormally easily "put out." If their opinions be called in question they will probably lose their temper, answer

questions in a loud and threatening way, and probably become aggressive if conversation be persisted in. Such patients flush readily, their eyes getting full and staring, their speech hurried, and generally they exhibit the signs of maniacal excitement. They are apt to be complaining and capricious in their moods. Their appetite may be greatly increased, and not easily satisfied. Frequently they indulge in noisy chatter, or in singing at the top of their voice, or nurturing schemes of revenge against some one or other, and it may be difficult to say how far such patients are responsible for their actions. At the same time, many of these cases may be subdued by austere treatment, and a bullying patient turned into a useful worker by being taken "firmly in hand" by a combination of attendants acting in concert.

Recurrent mania is recognised by periods of exaltation alternating with periods of depression and exhibiting a marked periodicity. It is as if there was an ebb and flow movement of badly guided nervous energy. The exalted moods may be true maniacal attacks with noisy incoherent chatter or pugnacious exhibitions and temper displays, or the patients may vent themselves in scolding or singing at the top of their voice, dancing, or other fantastic movements.

The periods of depression are frequently mixed up with listlessness and inertia of body and mind, a condition often bordering on stupor, and the patient may be apathetic or slightly melancholic. The condition, as a rule, is one of apathy rather than one of misery. The patients are slack and run down, and the softer emotions are shown by the mind of the patient brooding over death and the grave, and frequently the patients shed tears as doleful thoughts arise.

Recurrent mania is an inveterate form of insanity, and the patients seem to be quite well in the interludes of the disease, but the maniacal attacks recur again and again, and a state of dementia supervenes.

Mania may occur under an almost endless variety of forms —from acute typhomania to a simple chronic maniacal state, in which the patient is abnormally irritable, impulsive, and aggressive, but in whom no definite delusions can be discovered.

In monomaniacal forms of insanity it is astonishing how the minds of patients may be perfectly clear and sane on most things, yet a dark spot of mental obliquity is there, from which the patient seldom recovers. This form of insanity is probably slow and insidious in it origin, the general mental wellbeing of the patient deceiving the friends or the casual observer, until the mad idea has taken considerable root,

forming the centre of the mental circle of the life of the patient. The whole mental life of the patient may be complexioned by his monomania, which may be revealed in an endless variety of ways. Thus we have the middle-aged man, whose sole madness consists in the idea that he cannot swallow his food or that his food does not digest and he will not eat, or that he requires opening medicine when, in truth, he is in great need of having his stomach and bowels well filled with nutritious foods. These patients, chiefly men, are generally miserable-looking creatures, with gaunt faces and somewhat startled-looking, restless eyes, and in their character they are avaricious, untruthful, and evasive, and, in short, their moral courage is reduced to a minimum.

Again, many monomaniacs are given to day dreaming, and their dreams seem to them living realities. They may imagine that they are living in palaces, and have no end of wealth and grandeur; or again, they may be suspicious, and imagine their friends are burglars, thieves, and robbers. As a rule they are whimsical and capricious, sometimes being sweet and humorous in their ways, at other times scolding and extremely offensive, and the one state may succeed the other with lightning rapidity.

All forms of insanity tend towards a state of dementia with the lapse of time. In its complete form the patient is reduced to an automaton, will-less, and powerless for conserving and maintaining his or her life unless supervised by others. There are infinite degrees and grades of dementia, and at best it is a relative term. The acute forms of insanity, if not recovered from, are especially apt to end quickly in dementia, and this is especially true of adolescent insanity. On the other hand, climacteric insanity may go on for years before the stage of dementia is reached.

In typical cases of dementia there is great incoherence of speech and ideas, and the patient cannot be pinned down to talk of the subject matter on hand. What he does say is a mass of disconnected and rambling speech. It takes some effort to induce a confirmed dement to speak, and he displays considerable agitation when roused to the occasion. As a rule, such patients prefer to sit on their chairs and lapse into vacuity of mind. All dements are extremely lazy, wanting in volitional power, and having little or no spontaneity of mind. Many of them even lack the power of speech, but this is exceptional. In those cases that do not speak there is generally a melancholic cloud hanging over them. Demented patients are lacking not only in mental but also in moral

qualities, being untidy and dirty in their habits, and filthy over their meals, which they bolt down. Their appetite is often ravenous, and in a general way they have no controlling power over their animal passions. Their circulation is feeble, and they are weak in body as well as in mind. All their muscles lack vigour, and they move about slack and with hanging down heads. Their general nutrition is defective. They nearly all get thin, their hair becoming very dry, and it may stand out like bristles. Their memory is gone, but their reflexes, both bodily and mental, remain. Their sensitive faculties are greatly dulled. They feel less acutely than their sound neighbours, and they do not seem to catch cold readily. However, dements can be trained a good deal with patience and labour, and they are practically clay in the potter's hands.

II.

INSANITY OF THE DIFFERENT PERIODS OF LIFE: EVOLUTIONAL AND INVOLUTIONAL TYPES.

II.

INSANITY OF THE DIFFERENT PERIODS OF LIFE —EVOLUTIONAL AND INVOLUTIONAL TYPES.

THERE are three periods of life when insanity is apt to break out, viz., adolescence, climacteric, and old age. The first two are associated with the rise and fall of the organs of reproduction; the last with the decay of the body and mind.

During the period of adolescence there is a great strain on the system from the sexual organs developing rapidly. Along with this development there is a marked normal mental change. The young man (or woman) is losing his unity and becoming more and more an integral part of society. He is becoming more and more altruistic in his ways, and his chief concerns, instead of being immediately centered in himself, now are for others —"He that seeketh his life shall lose it." Religious and amatory sentiments are prominent tokens of this state of adolescence, and adolescent insanity is essentially one of unbridled passions.

Young lads are more subject to the disorder than girls, menstruation perhaps being a sort of safety valve in females. The type of case that becomes insane at adolescence is essentially one coming off a neurotic stock, with a highly impressionable nervous system.

Sexual troubles are greatly mixed up in this disease, and there are few, if any, adolescent lunatics who do not indulge in the habit of masturbation to an inordinate degree. The mothers of such patients generally say he was such a quiet lad and did not keep company and went to the meetings—prayer meetings. Clearly, all through the disease, and the stage leading to the disease, there has been a morbid subjectivity of mind. There has been "I thought this and I thought that," when it was no part of the business of the young man's life to

think anything of the kind, but to live on and for the external world around him, paying no heed to his bodily functions, or giving way to melancholic morbid introspections. These adolescent patients are quiet and gloomy, and lead abstracted lives. They are, so to speak, all egotistically insane, and the treatment consists in recalling them from the world of dreams to the practical one of hard muscular labour—something manual as opposed to something mental. Their bodily health is generally greatly defective. They are frequently thin and pale, and having the appearance of being overgrown.

The outbreak of adolescent insanity generally takes the maniacal form, but it is a fugitive mania if they are properly treated, and one very apt to become chronic and to lapse into dementia if great care be not used.

During the maniacal stage the patients become greatly exalted and uproarious in speech, and inclined to be very aggressive, and even homicidal. The family ties of affection become greatly impaired, and the patients not infrequently evince a strange antipathy to their best friends. Hallucinations of hearing are almost always present. They hear voices goading them to do this and to do that, and as a consequence they are subject to sudden impulses, and may be really very dangerous to others. Sudden impulsive movements are a very striking feature of adolescent mania. Mentally they are greatly exalted and excited, have numerous grandiose delusions, which probably had their birth in the antecedent visions of power and ambition that floated through the young man's mind before he actually became insane. But the tendency all through the disease is towards erratic manifestations of perverted mind action—a sheer instability of mind and matter. If the disease assumes a melancholic form, there may be the most uncontrollable impulses towards suicide, and there are few, if any, forms of insanity where these destructive desires reach such a culminating point. In those suicidally inclined patients the eyes may be wild looking, and when the face is pale and the pupils dilated the facial expression is one of terror. Obstinate refusal of food is not uncommon in the melancholic forms, and the patient may require great firmness in dealing with him. Hallucinations of sight are not so common as those of hearing, but they may exist in the acute stage of the disease. Increase of body weight is an excellent indication of improvement.

Treatment should consist in mental distraction during the acute and subacute stages, with muscular out-door labour and plenty of good nourishing foods. Clouston lays special stress

in giving them abundance of nourishment, chiefly in the form of milk and eggs. The bowels require careful looking after, and tonic treatment is greatly needed. Iron tonics, &c., cod-liver oil and malt extract, are very useful if the stomach will bear them. Masturbation habits require looking after. Great cleanliness of the body is a great help here with good bowel action in the morning, aided if necessary with a teaspoonful of Epsom salts in one-third tumblerful of water before breakfast. The bromides, also, are very useful to allay sexual desires, and if hypochondriacal symptoms exist, the passage of a large-sized bougie occasionally will do good. When the acute symptoms pass away, the social instincts of the patient require fostering, as this will be the best prophylactic in future. The disease, in my opinion, is one induced by self-living and self-exhaustion by bad habits and otherwise. If catarrh of the stomach be present, and the patient refuse food, lavage of the stomach will be necessary along with liquid foods, until the digestive power is restored.

Climacteric insanity occurs in women about the period of the menopause, and in men about the middle period of life—40 to 50 years. It is most typically represented in women, and is associated with the deline of the organs of reproduction —with the cessation of the lochia. About this time, women in health frequently suffer from a multitude of vague symptoms —flushings in the head, singing noises in the ears, headaches, various neuralgic and dyspeptic symptoms, with very often a loss of mental stability, as revealed by a slight loss of self-control. These are warnings that the vital dynamics of life are undergoing changes, and it is no wonder if the mind should suffer from irregular distribution of nervous energy. It is a period when the mind is apt to recoil upon itself and contemplate its unsatisfied longings, unfulfilled ambitions, and disappointed hopes. There is a rise of the "Ego" at this period. Should insanity break out, it is one characterised by persistent and deep-rooted delusions, and the prognosis is not at all favourable. It is the period when monomaniacal forms of insanity become rampant, and this is in accordance with what is stated above.

Subacute maniacal attacks are very common now, exhibiting a marked periodicity, and this would lead one to suppose that they are a good deal connected with the cessation of the catamenia.

Delusions of grandeur and noble lineage occur frequently, and, generally speaking, the delusions partake of an exalted character. Hallucinations of hearing and smell are not un-

common in climacteric insanity. It is a form of mental disorder in which organic lesions in the brain can scarcely be found to account for the symptoms.

The treatment should have regard to the circumstances under which the insanity broke out. We cannot appeal to defective bodily health in this disorder, as we can in so many other forms of mental disease, as the patients are generally strong and robust-looking. We must seek to guide the perverted nervous energy into healthy channels. Light employments calling the muscles into play are the most suitable, such as housework. Maniacal outbreaks may be subdued by the timely administration of a smart purgative and frequent doses of the bromides. Nervine tonics are useful, such as arsenic and strychnine, but iron combinations, as a rule, should not be given. The excretory organs should be well looked after, and the general rules of healthy living observed. The majority of the patients will require asylum treatment, as many of them are not only homicidal but even suicidal.

In men the disorder is apt to assume a hypochondriacal form, with various delusions regarding the organs of the body, the patients frequently refusing food and requiring to be fed by the stomach-tube. These patients generally seem run down, and perhaps treatment based on the lines of the Weir-Mitchell treatment would do good.

Senile insanity occurs in its typical form in persons over 60 years, and is associated with the decline of the vital powers with organic changes (premature or otherwise) in the heart and arteries. In the vast majority of cases the vessels will be found altered, being atheromatous and thickened, and their walls not infrequently containing calcareous deposits. The disease is associated with softening and atrophy of the cerebral cortex, probably dependent on the altered blood-vessels and heart. The left ventricle of the heart is frequently found hypertrophied, and the valves thickened and puckered.

Connected with these pathological changes we have various symptoms—loss of memory, particularly for recent events; childishness of disposition, and a feeble circulation with cold hands and feet; inertia of body and mind. Gradually the patient becomes more and more demented, and death may be precipitated by hæmorrhage into the ventricles and pons of the brain, or the patients may gradually sink from exhaustion and hypostatic congestion of the lungs. Slight traces of albumen are not infrequent in the urine. If the patients get exhausted they are apt to get drowsy and partially comatose,

apparently from the defective circulation through the brain and the faulty elimination of waste products. Senile insanity should not be confounded with dementia of old chronic lunatics. Nearly every case suffers from melancholic symptoms, having no heart for anything and lacking spontaneity of action. They are gloomy and sad and tired of life, and desire to be away from the company of their fellowmen. They have dejected countenances, often with a pathetic look in their eye. Very often one finds that their skin is dry and hot, and they seem to be burning away with a slow fever; yet, beads of sweat stand out on their forehead under the influence of slight excitement, such as the exertion of taking food. When confirmed dementia sets in they may be very restless and noisy, continually mumbling away to themselves, and lazy and dirty in their habits. Their sleep, as a rule, is broken and non-refreshing. Delusions of identity may be present, and the mind be filled with grievous apprehensions of bodily harm about to be inflicted upon them. Distinct improvement may occur from time to time under good nursing and care. Thus some patients are admitted into an asylum wandering and confused in their mind, and really not knowing well what they are doing. A few months afterwards their minds may be quite lucid, although enfeebled. Sometimes the patients are very restless and fidgetty, and cannot content themselves on their chairs, and they are not very amenable to discipline, as they forget the good precepts that the nurse or attendant may inculcate.

Treatment should consist in keeping the patients clean and making them comfortable, with rest in bed in cold weather if the circulation be weak. Quinine seems about the most useful drug to use. The bowels should be relieved twice or thrice a week with an enema or the administration of a dose of castor oil. Digitalis and spirits of sweet nitre are occasionally useful, if the patients become slightly comatose. Prognosis is often good for temporary improvement, but gloomy as far as recovery is concerned.

P.S.—In some cases of senile insanity where the arteries are very bad, there may be incessant noises heard in the ear, and the patient may construe these noises into the voices of men, and various delusions be manufactured relating to Fenians, dynamite, electric batteries, &c. Indeed, it seems probable that many hallucinations arise from misinterpretations of abnormal sensations arising through defects of the sense-organs.

III.

EPILEPTIC INSANITY (THE DEMONSTRATIVE MANNER OF EPILEPTICS) AND PUERPERAL INSANITY.

III.

EPILEPTIC INSANITY (THE DEMONSTRATIVE MANNER OF EPILEPTICS) AND PUERPERAL INSANITY.

Epileptic insanity is typically represented by quiet periods of mental life, suddenly broken by passing mental storms, the latter frequently casting their shadows before them. Many epileptics go on for days and weeks and even months, as quiet, agreeable, and industrious patients, when some day their mental reflexes begin to get more acute, as shown by an irritable, disagreeable, and fidgety manner, to be quickly followed with one or more convulsive seizures. The explosion may be vented in a motor convulsion—the common way—or escape by other channels, *e.g.*, it may be a sudden homicidal blind fury or fit of temper, with noisy threatening speech, with angry saliva gathering in the mouth, or it may be a pure mental disturbance (choked fit) in which the patient experiences considerable mental anguish from pent-up nervous energy, and is restless, distressed, and sheds tears of misery, wringing the hands, perhaps, in despair. The writer has observed that a great many epileptic lunatics are characterised by a *demonstrative manner*. They seem to have all their reflexes abnormally acute, and their muscles are often stammering like their tongues. Many epileptic lunatics in ordinary conversation gesticulate a great deal, often displaying tragic attitudes, especially with their right hand, and not a few of the male epileptics keeping poking one in the ribs, as if to drive "their point" home, and they seem unconscious of these awkward habits. Again, in quiet discourse, many epileptic lunatics become fidgety and restless, jumping to their feet and apparently lacking in ordinary self-control.

A strained form of religious sentiment is quite a feature of insane epileptics. The knee-jerks are frequently highly exaggerated, but not always. Then, epilepties are often revengeful and vindietive, and require the greatest tact and eare in dealing with them. Their habits are often gluttonous, but generally they are tidy in their person. There is a great deal of vaso-motor disturbance in epilepsy. The pupils dilate readily under slight stimuli of excitement. Large quantities of elear pale urine are often passed by sueh patients, and they frequently rise out of bed during the night to unload their bladders. The etiology is obseure. It is a disease affeeting a neurotie stoek ehiefly. A history of tapeworm in ehildhood is not uncommon. The writer knows of a boy who suffered from epileptie fits from his seventh to his eleventh year, when they suddenly left him; but, unfortunately, at the age of 21, they returned.

In the way of treatment, all sourees of peripheral irritation should be sought out and eombated. There is generally an instability of the nervous system in epilepsy, an abnormally easily put out condition of all the mental funetions, and it is elear that the treatment should be sedative, tonie, and caleulated to make a vigorous organism.

Puerperal Insanity.

Puerperal insanity oeeurs generally within a week after pregnaney, and seems to attaek youngish women ehiefly. There may or may not have been septie infeetion, but it is doubtful whether this is invariably the ease. It is a definite illness, runs a definite eourse, and with good nursing and general bodily treatment nearly every patient affected ought to make a satisfactory recovery. The mental symptoms depend upon the bodily conditions, and may safely be neglected, and all therapeutie resourees be coneentrated on reetifying body-eonditions—the mind reeovers when the body is put right.

The illness is ushered in by an alteration in the manner of the patient. She beeomes "queer," restless, and sleepless. The temperature generally rises a few degrees, but not always. All the sense-organs beeome preternaturally acute; slight noises jar and upset the patient, henee the absolute neeessity for quietness and seelusion for these patients. No talking friends should be allowed to see the patient until she is eonvaleseent. The doetor and the nurse alone should see or speak to the patient.

The majority of the patients beeome maniacal, but their maniacal excitement has a melancholic complexion. There are generally hallueinations of hearing and sight present, the patient hearing the voiees of friends or strange sounds of all kinds; she may see beasts, or the devil alluring her to destruction. Generally, the delusions have a religious aspeet, and commonly relate to religious shortcomings and soul-perdition, and the patient is generally in great agony of mind, perhaps shouting, "Oh! my God! what have I done?" or perhaps dwelling on imaginary wrongs done to her husband. The maternal instincts are early impaired and lost. The patient very frequently attempts to kill her ehild by strangulation or in other ways. Flashes of light are commonly seen before the eyes.

In typieal eases, there is great agony and distraction of mind. The pupils are usually dilated, but all their reflexes may be normal. The appetite for food is lost, the patient suffering too mueh mental pain to heed food or anything else. There is generally an expression of great terror on the faee, whieh is, as a rule, pale, the eyes being full and staring. The great exeitement of the patient may have to be met by the use of a padded room or extra nurses, or hyoscine and sulphonal or other hypnoties may be required during the earlier stages to proeure sleep. As a rule, the patient will drink liquid food, and the stomaeh tube is seldom requisite for feeding them.

When the mental agitation subsides, it is sueeeeded by a state of depression and apathy, the patient minding little about friends or life itself. At this stage, there is well-marked morbid introspeetion noticeable on the part of the patient, and, as a rule, they are quiet and slow in unfolding their minds to to the doetor.

They have now recovered their senses, and express a strange antipathy to their relatives, partieularly the husband. They now lie in bed quiet and exhausted. Even at this stage the exeitement of a visit from friends may completely upset them and retard their progress. When the stage of reaetive depression begins to pass away, an emotional weakness is commonly observed, the patient shedding tears at trifling provoeations. The higher faculties of the mind—the reasoning and will power—are the last to be restored.

When recovery takes place, the patients seem to remember very little of what happened during the acute stage of the disease.

In regard to body symptoms, there is generally a febrile temperature lasting about three weeks, the temperature curve

exhibiting great oscillations. Occasionally the temperature may reach 106° F., and cold sponging and antifebrin be necessary along with stimulants. Slight causes disturb the temperature, even after it is normal. Excitement of visits from friends and constipation may send it up three or four degrees. The quantity of urine passed in twenty-four hours is markedly diminished. I have seen it amounting to nothing more than 7, 8, 10, or 12 oz. daily, and that may be the state of matters for many days, and yet there has been no dropsical condition present.[1] I have observed a slight trace of albumen in the urine in the acute stage of the disease in the cases that have come under my observation. The lochial discharge is often of foul smell, and may be scanty or absent altogether. Great bouts of sweating is a common symptom, particularly during the night. The pulse is feeble and quick. A few bronchitic râles at the back of the lungs are not uncommon.

The treatment essentially required is rest and seclusion, good nursing, plenty of light and pure air in the sick-chamber, good nourishing foods—milk, beef-tea, switched eggs, &c.—regulation of bowels by castor oil or enemata; sulphonal for sleep. Hypodermic injections of hyoscine is of great value if maniacal symptoms be prominent. Cold sponging and antifebrin for high temperature, with vaginal injections of weak carbolic lotions, and occasionally an intra-uterine injection of same if circumstances demand it. Stimulants, at times, also may be required. I administered an intra-uterine injection of carbolic lotion (1 to 40) to one patient whose lochial discharge was foul, and the temperature 106° F. There was a great gush of blood came away, preceded by some old clots. A second injection, given a week afterwards, was not followed by any untoward symptoms. The state of the uterus and vagina requires attention as much and more than the mind in these patients. The mental symptoms are undoubtedly the expression of altered bodily conditions.

During convalescence, light employments, gentle exercise in the open air, plenty of strong foods—beef, eggs, fish, &c.—with tonics—iron, arsenic, strychnine, and quinine—are about all the remedies likely to be required to make the recovery of the patient a satisfactory one. The patients should be supervised for a period of two to three months, and occasionally longer.

[1] These facts have led me to believe that the dropsy in tubal nephritis is probably due to the loss of albumen rather than to the diminished excretory flow.

IV.

GENERAL PARALYSIS OF THE INSANE.

IV.

GENERAL PARALYSIS OF THE INSANE.

GENERAL paralysis of the insane is an intractable disease characterised generally by a steady—sometimes intermittent or remittent—deterioration of the whole nervous system, and eventually revealing itself in paralytic phenomena, death commonly succeeding the outbreak of bedsores and bladder troubles. The etiology is obscure. The malady is associated with riotous modes of living, excess of the animal passions, drinking, and debauchery. Syphilis is a good deal mixed up with it, but not always. The mind of the patient is generally exalted during the earlier stages of the disease, but rapidly deteriorates, and all expression of mental life may have vanished sometime before the patient dies. The *post-mortem* lesions commonly found are thickening of the cranium and membranes of the brain; adhesion of the latter to some parts of the cranium and the brain. The convolutions of the brain are generally greatly atrophied, and commonly flatter than normal; the sulci are wide, the brain substance is very soft, and the lateral ventricles frequently greatly dilated. The cord and membranes may be affected in a somewhat similar fashion, and, as a rule, there is a great increase of cerebro-spinal fluid. The whole morbid appearance suggests a chronic cirrhosis, with atrophy and softening of the nervous system. An atheromatous state of the arteries is always associated with this disease as far as my experience goes. A slightly cirrhotic condition of the kidneys is of frequent occurrence, yet there may be no albumen discoverable in the urine, at times, as far as the tests—picric acid, heat with delicate acidulation, and HNO_3 in the cold—are concerned. The valves of the heart are found frequently thickened and atheromatous, and the left ventricle enlarged. Paraplegia is of frequent occurrence; and generally in the last stage of the disease the legs get drawn up, and the knees may lie on the chest, and the muscles of the

arms—and especially of the legs—may stand out like stiff cords and resist attempts at changing the position of the legs. Bedsores develop generally over the sacrum and trochanters, but they do not discharge much pus—a sort of local dry gangrene, with a black slough in the centre.

An extreme motor restlessness is one of the most common symptoms of this disease. The patients are very troublesome to nurse, on account of their restless, aimless, and purposeless excursions about the room, and also with their hands when sitting on their chairs. They are, as a rule, destructive and filthy to a degree in their habits; tearing their clothes, undoing their trousers, and hoarding and swallowing rubbish. They seem to have an exuberant sense of well-being, like a person drunk on wine. They are absolutely indifferent to the feelings of others, and have no moral sense left. It cannot be said, however, that they are introspective. This is not a common symptom of this malady. There is a strong tendency to building castles in the air, and nurturing visions of grandeur, and splendour, and high birth, but this is not always the case. Yet, the general paralytic is not serious in his views. He does not resent his visions being torn to pieces, but seems to enjoy the merriment of his neighbours at his own expense. He is not abashed or humiliated in the least. Not only is the typical general paralytic restless in his muscles, but there is a great exuberance of noisy speech and clatter, and a strong tendency to harp on the one key. Thus, one general paralytic kept for weeks and months, in parrot-like style, shouting out in semi-musical cadence, "one, two, three," varied with occasional interludes of "cushie-la." Grandiose delusions regarding wealth are perhaps the most common. A whining, complaining mood is occasionally seen in some general paralytics in whom the disease is progressing slowly, and in whom a certain childishness of manner is the most striking feature of their general mental habit.

General paralytics, as a rule, take their food well, but they are not capable of concentrating their energies on any useful work. As a rule, they gradually lose weight, especially if maniacal symptoms be prominent. The pupils are frequently unequal, and sometimes irregular in their outline, and do not respond well to to the stimuli of light. The fine lines of expression around the mouth are wont to become blurred or obscured, and the tongue when protruded frequently exhibits little tremulous movements, sometimes a quivering wave passing transversely over it. As a consequence of these mild paralytic phenomena, the speech is not so clear and the

enunciation not so distinct as in health. There is a noticeable faltering in speaking—a distinct slurring of labial sounds. Although the lines of expression around the mouth may be, and are generally obscured, yet the other facial lines may be well marked, and the rest of the features be quite clean cut.

The handwriting is commonly affected. It is unsteady, lacks firmness in the lines, is disorderly looking, and the ends of the words are clipped off. The emotional side of the general paralytic may be exaggerated, especially in women. There is a noticeable disposition on their part to indulge in fits of crying and a proneness to shed tears at unexpected moments. In one female general paralytic, who undoubtedly had syphilis, the hair fell out and became quite downy, like the young of birds shortly after birth. But the hair grew again in this case, perhaps on account of the mercurial treatment that was used.

Before death, there is generally extreme emaciation, but not always, and swallowing becomes gradually more and more difficult, until, at length, sloppy food only can be administered. For weeks, and sometimes months before death, all expression of mental life may have died away. Even the power of articulate speech may have gone, and the only thing the patient may be able to say, and that only as a kind of wail, is "Oh! yes!" and even then only when the patient is severely pinched and pained. A motor restlessness remains generally to near the end of life, and the patient may get incessantly out of bed, making and unmaking the bed. In my experience the urine as regards colour, the absence of albumen and sugar, may be normal, although the specific gravity may be low.

I have said the patients are heedless of others, and in this connection we may notice the family feelings of affection and the maternal instincts are greatly impaired, and often lost altogether, but not always. Indeed, this is a disease of protean character, and there are few, if any, constant phenomena. The disease is often said to have a twofold aspect of origin—a spinal and a cerebral. Thus, the mental symptoms may herald the disease, or tabetic ones may form the prelude. It is probable that the disease known as general paralysis may be in future resolved into several groups, but it seems to me that those cases with well-marked mental symptoms must always remain as a distinct group to justify the term general paralysis of the insane. It is easy to quibble over words, and say the paralysis is special, not general. But the word general is a convenient term to indicate the wide-spread character of the disease. We

may have a cirrhosis of the whole nervous system, just as we have cirrhosis of the whole of an organ, such as the liver. Undoubtedly, the perplexing forms of general paralysis arise from the pathological lesions, not always starting in the same site, and not always progressing in the same manner, but the final goal is a complete involvement of the whole cerebro-spinal axis. In the later stages of the disease, the eye symptoms may become marked, the result of great impairment of vision, and paralysis of various muscles of the eyeball revealing itself in non-consensual action of the eyes, both as regards the pupils and the eyeballs themselves.

When bedsores form, they are generally succeeded by others, but they may heal quite well under local treatment. Before death, the bladder loses its power, and the urine dribbles away. Gastric troubles are not conspicuous in this disease; indeed, it would seem the other way. Respiration may become affected during the last stage of the disease from œdema of the lung. Cheyne-Stokes breathing may or may not precede death. Short, repeated, and incomplete convulsive seizures often occur in the later stages, and they are supposed to be due to "congestive" attacks, but they generally pass away. A few days before death the extremities, particularly the hands, get blue, and red, and congested-looking, and sometimes the skin peels away from local death. This phenomenon occurs in many cases of insane patients dying, and is perhaps of trophic origin. Occasionally, large solitary bullæ form, especially about the shoulder, containing clear serum, and drying up in a few days. This is not uncommon in other forms of insanity, and is probably of trophic origin.

The disease is typically represented by a course of two to three years' duration, but undoubtedly there are cases of a very chronic type that may last five to seven years and even longer.

There are two types of complexion we may recognise in this disease—(1) There is the sallow parchment-looking individual, or pale pasty complexion, and I have thought that syphilis is a good deal mixed up in most of these cases; (2) a type with a rosy flush on the cheek, greasy state of the skin of the nose and forehead, and sometimes with glittering eyes. But any attempt to define the physiognomy of the disease must be extremely arbitrary. General paralytics often become—and that quite suddenly—dull and stupid, and very incoherent, or apathetic and listless, and they may "brighten" up again in a few hours. The writer has noticed that a good many general paralytics complain, when closely interrogated,

of a pain over the vertex of the head, and this is interesting when we consider the frequency with which the membranes of the brain are adherent to the cranium about this site or to the brain. The gait of a general paralytic is somewhat peculiar. It is like his handwriting, it lacks firmness and stability. A loose, rollicking movement of the body in walking is common; walking firmly and perfectly straight is the exception.

The pathology of the disease is most interesting. One accustomed to observe the lesions of other organs than the brain can scarcely help coming to the conclusion, when watching the *post-mortem* appearances of the nervous system of general paralytics, that the disease is essentially a chronic cirrhosis, accompanied by wasting and softening of the nervous tissue. The thickened adherent membranes have their analogue in the pleuritic membranes in pleurisy; the granulations in the fourth ventricles of the brain suggest to the mind the granulations of another organ—the kidney in Bright's disease. Is the disease a chronic interstitial inflammation or a degeneration pure and simple? We know that the former is liable to be attended by degenerative processes. Gull and Sutton, on the other hand, believed from their researches in Bright's disease that there was a degeneration—the hyalo-vascular—that may affect all the organs and vessels of the body, but not necessarily simultaneous; then, this new theory might be advanced. No doubt, it is a limited view to associate all forms of arterial degeneration with kidney disease. It is not uncommon to find very much thickened arteries in chronic phthisical subjects, even after all active manifestations of phthisis have died out, and the patients seem to be quite well. Arterial changes are not linked with one bodily disease, but with many. Undoubtedly, cirrhosis of the kidney hastens this change in a remarkable manner. At the same time, both the changes—kidney and arterial—may originally be induced by one and the same morbid condition, say of the blood. Yet, the disease of the kidney adds a fresh and serious element favouring arterial degeneration. We have good clinical grounds for believing that there are certain cachexias of the blood that may bring about wide-spread cirrhotic changes, but these morbid blood states require further elucidation. In a general way, we may speak of them as toxic states of the blood. Chronic gouty blood is a well-known condition for favouring and inducing cirrhotic changes, particularly of the kidneys, joints, and valves of the heart and blood-vessels generally, and emphysematous states of the lungs and softening of the brain, generally preceded by arterial changes. But gouty blood, as

far as I know, does not bring about general paralysis. Secondly, a chronic rheumatic condition of the blood induces changes similar to those induced by gout, but, here again the brain is not the organ of election for morbid action, yet we know the brain may be sometimes affected—cerebral rheumatism of Trousseau. We have still to find the blood cachexia, if there be one, that induces general paralysis of the insane. The fact of syphilis being frequently the undoubted cause of general paralysis strengthens our belief in a blood cachexia in this disease. Possibly, inordinate drinking of bad spirits may have something to do in inducing such a state. Debauchery and excessive venery form, to my mind, the predisposing causes of this disease. They tend to produce and keep up an active hyperæmia of the nervous system, and it is not at all difficult to conceive of a toxic state of the blood completing the chronic inflammatory change. Again, the exalted, restless, and maniacal character of the patient during the early stage clearly betokens that there is an active morbid change at work. We can scarcely imagine a quiet, simple, intrinsic degeneration accounting for these symptoms.

The earliest symptom of this disease I have been able to trace is restlessness of body and mind. Getting up out of bed at night and wandering in restless fashion through the house is about the earliest symptom. The patient cannot find peace in bed, and wants to be about, perhaps sitting at the fireside brooding and not knowing well what is the matter with him. This, then, may be the very first indication of the disease. Secondly, follows a mischievous and irritable condition, the patient requiring great nicety in manging his temper at home, and after that the disease is generally well established. If such be the clinico-pathology of the disease, then follow certain well defined indications for treatment. The early stages of the disease must be met by sedative and calmative measures. I would suggest all stimulating food and drink to be interdicted, and the patient put on a vegetable and milk food dietary. Secondly, the skin should be appealed to to relieve the deep-seated nervous system. To my mind, gentle and prolonged diaphoresis might be kept up for months by the use of warm baths, or perhaps jaborandi. Undoubtedly, general paralytics improve in warm weather, but this applies to nearly every ailment. Regulation of bowels; bromide and iodide of potassium might be given; the former for its calmative effects. the latter for its well-known action over chronic inflammations. A few leeches to the nape of the neck might be an advantage. Blisters, strychnine, &c., might be used for after-treatment,

When the disease is far advanced, these measures would probably be fruitless, and might do more harm than good, but I consider they fulfil the rational indications for treatment during the earlier stages of the disease. I would confine the patient to bed during the above treatment, believing that absolute rest to body and mind is urgently needed.

As far as I know, general paralysis is generally treated on purely hygienic grounds. There has been no serious attempt to deal with it as an acute or subacute disease, and a stray recovery here and there has been reported. These recoveries being so rare, the profession has got to believe the disease is invariably fatal, and, as a consequence, the patients are made as comfortable as possible in our asylums, and perhaps get soporifics, but that is all that can be said. I am of opinion that, if the patients could be got in that early restless stage, something might be done for them.

P.S.—Grinding of the teeth is not an uncommon symptom in general paralytics who are bedridden, and it is a sad spectacle to watch a general paralytic continually grinding away his teeth, until they are so worn down as to resemble those of a horse about twelve years old. This grinding of the teeth resembles, in a general way, the chewing of the cud in cows. I have only noticed it in general paralytics. It is a sort of automatic grinding, going on incessantly, unless the patient be asleep. Perhaps some would consider it a fresh proof of the Darwinian theory of evolution. In this connection, I cannot help remarking the condition of two imbecile twin sisters about 19 years of age. They would sit, if permitted, all day long in their chairs, working with the tips of the fingers of both hands, as if they were picking at objects, very much in the same way as monkeys behave.

But, perhaps, the most striking feature that one observes in a body of lunatics is that, in insanity, the social instincts are among the first things to be lost. This loss become absolute in profound melancholia and confirmed dementia.

V.

ON CERTIFYING LUNATIC PATIENTS AND THE GENERAL PRINCIPLES OF TREATMENT.

V.

ON CERTIFYING LUNATIC PATIENTS AND THE GENERAL PRINCIPLES OF TREATMENT.

Medical men in active practice frequently experience considerable difficulty in certifying patients as being of unsound mind, and requiring detention in an asylum, on account of not having had opportunities of becoming practically acquainted with the different phases of madness. Consequently it is not too much to say that lives are annually lost through timid and faulty diagnosis. Not only are the lives of patients thus lost, but also sometimes those of their friends through the diagnosis of insanity not being completed until some visible disaster has occurred.

As a rule, medical men in general look for some outstanding delusion as their chief guide in framing a diagnosis. Yet, from what has been said in the preceding essays, it may be gathered that that may be difficult to elicit, and sometimes impossible.

To certify that a patient is of unsound mind may be an easy matter in some cases if the signs and symptoms of his madness are conspicuously present—*e.g.*, the patient may be raving mad. Again, it may be most difficult to do so if the patient has lucid intervals in his disease, or if he be a monomaniac with fleeting delusions or with delusions difficult to elicit.

It is necessary not to confine oneself in the investigation to the mere presence or absence of marked delusions. There may be homicidal or suicidal tendencies, or attempts may have been made in these directions. There may be hallucinations of sight and hearing present, but these symptoms are chiefly to be found in acute cases in which the diagnosis is least difficult.

In a general way, it is well to begin by ascertaining if the

patient is suffering from any acute form of mental disease. Does the condition point to the malady belonging to the group of diseases associated with maniacal states, or with melancholic states, or with demented states? Then a knowledge of these disordered states of the mind will come to our aid in completing the diagnosis. Monomaniacal and epileptic forms of insanity will occasionally offer difficulties. In epileptic insanity we must search for evidences of violence, defects of speech, confusion of ideas, &c.

Again, there are some forms of insanity where, instead of perversion of the mental faculties, we find defects. If a man in fair bodily health will not work, being defective in mental energy or will power; if he persists in lying in bed all day for weeks or months, and harbours hypochondriacal notions about himself and shows no signs that he feels himself a responsible creature, he is clearly of unsound mind, and may be certified as such and as requiring supervision by others; but the wording of the certificate may be troublesome to an unpractised hand. The facts—that a patient "cannot do" for himself, and is heedless and regardless of himself and his neighbours; or is incompetent mentally to guide himself, being foolish and rambling in speech and silly in conduct; or is unduly irritable, impulsive, and aggressive; or listless, apathetic, and confused in mind; or morbidly suspicious and homicidally inclined; or restless, incoherent in speech, and disorderly or defective in mind, with loss of memory and childish indisposition—are all of great importance in framing a certificate of madness.

It is essential in filling up a certificate of lunacy to attend to the clerical part of it, and state fully and accurately names and addresses and dates, as many mistakes of commission and omission are made, and the sheriff may regard the certificate an invalid one on that score, while, of course, he is not usually able to dispute the facts on which the diagnosis that the patient is of unsound mind rests.

In approaching a patient supposed to be of unsound mind one should exhibit no trace of nervousness, especially if the patient be suffering from maniacal excitement; but, keeping one's wits about him, interview the patient with some degree of boldness and confidence. With morbidly suspicious patients it is best to be frank and courteous, and investigate the mental condition from a variety of standpoints, so that if the patient's mind be lucid on most things, his weak points will be detected—*e.g.*, delusions of a religious, amatory, and financial nature, &c.

Principles of Treatment.—In treating cases of insanity there are certain general principles of treatment that should be kept steadily in mind. If the disease be acute, attended with maniacal excitement, it is obvious that all sources of irritation should be as far as possible removed, in order that the disordered brain may get as much rest as possible. Consequently, in such cases the patient should be kept in a quiet chamber, free from the excitement of noise and social intercourse with his neighbours. Cleanliness, abundance of fresh air and light, with suitable nourishing foods, are all important. Sleep should be secured by as much out-door life as possible, if the patient's strength will permit of his being in the open air. It is well, also, in all cases to remove the patient from the surroundings under which his madness developed. Consequently, asylum treatment is requisite in most cases, especially where expense is an object of concern. The mad ideas which trouble and torment the mind must be dispelled by endeavouring to supplant them by healthy ones.

Discipline which consists in the regular discharge of duties should be a prominent factor in treating cases of madness. Healthy habits are thereby secured, which are in themselves powerful aids in the cure and powerful weapons in prophylaxis. The will power in all cases of insanity is more or less impaired, and stronger wills must guide the weaker ones. Consequently, the strength of character of the physician is of the highest importance, and in proportion as that obtains so will benefits to the sick follow. In dreamy and vacuous states of mind rousing treatment is necessary. An idle brain is bad for the sick as well as the healthy, except in very acute cases of illness. Active manual pursuits are valuable in dispelling soft and listless states of the mind. The emunctories of the body should be kept well open, as retention of waste products in the blood is perhaps the most powerful factor in the production of melancholic and depressed states of the mind. This implies the judicious use of baths, aperients, diuretics, cholagogues, and exercise in the open air. When to soothe and when to stimulate the brain is the crux of most of the mental treatment.

Dietetic treatment is of great consequence. We know that nitrogenous foods are necessary for the repair of tissues, and that the fats and starches and sugars are chiefly heat and force producing foods. Advantage should be taken of this knowledge in administering abundance of nitrogenous foods to repair the wasted and recruit the devitalised forms of many lunatics. In acute diseases we must be content

with liquid foods for the most part; but a free use of nitrogenous foods would, I am sure, in a large measure supply the one thing needful in not a few cases of chronic insanity. Even a free allowance of tea, bread, and potatoes will scarcely make any material difference in the weight of many chronic lunaties, while an egg eustard daily will often increase their weight perceptibly in one week. And in this conneetion great eredit is due to Clouston, who has been a pioneer in advoeating feeding of cases of insanity.

I would advocate a more liberal allowanee of cheap nitrogenous foods in our parochial asylums, where expense in this direction seems to be so distasteful to the managing boards. I consider three good nitrogenous meals daily absolutely necessary to get the best results. In my experienee, both with lunatic and non-lunatic patients, health and strength and weight are best obtained by increasing the proteids rather than the carbo-hydrates in the diet. The uric aeid theories of gout seems to have cramped our notions of the value of nitrogenous foods in treating chronie diseases.

A problem that frequently arises is how to break recurring mad habits. Many patients get well for a time, then relapses take plaee. It seems to me that, if the diet were properly looked after, as above indieated, a great advantage would be got towards preventing recurrent attaeks. Disease and weakness go arm in arm, not disease and strength. Maniaeal excitement is an indieation of brain weakness, not of brain strength. Then, of course, diseipline whieh fortifies the mind and inereases will-power and strengthens inhibitory aetion is likewise a powerful aid. Further, eertain medieines by bracing the system may be of serviee—*e.g.*, arsenie, iron, stryehnine, phosphorus, and quinine, along with eod-liver oil and malt extraets. Other medieines, by diminishing reflex irritations, may be advantageously employed—*e.g.*, the bromides. Thus, one patient who had searcely slept any for months, when put on full doses of bromide of potassium every few hours during the day, got baek the habit of sleeping in the course of a week or two.

In recurrent mania it seems to me the patient should be seeluded on the first indication of an attaek, and quiet and rest enjoined to body and mind.

Smart purgation, *e.g.*, by croton oil (2 minims), lessens maniacal excitement, possibly on account of its exhaustive effects, but I also think on account of its derivative action on the brain.

Frequently one has occasion to feed patients by the stomaeh

tube. To do this skilfully requires some knack. It is pitiful to see a bungling hand torturing a patient in attempting to pass the tube into the œsophagus. A good plan is for an attendant to sit on a chair, with the patient sitting on the floor with his back to the attendant and partially clamped between his knees, his arms likewise being secured. The mouth is then gagged, and the tube lubricated with soap. Two fingers of the left hand should be placed over the tongue of the patient. The tube should then be conveyed to his mouth, and passed over the fingers to the back of the pharynx. If the tongue be now well depressed and slightly pushed forwards, the tube will readily pass if urged onwards and slightly to one or either side, so as to avoid the epiglottis. When the tube has well entered the œsophagus the fingers of the left hand may be slightly relaxed, in order to give the patient a breath or two. If any difficulty be experienced, one of the fingers on the patient's tongue may guide the point of the tube, when it will be readily passed. When the tube is passed the rest of the steps in feeding is quite simple.